This author believes that resection and removal of the head of the bone is preferable to any other method of treatment, as by osteotomy either of the neck of the femur or through the trochanter.

Surgical Intervention in Traumatisms of the Heart and Pericardium.—CESTAU (*Gaz. Heb. de Méd. et de Chir.*, 1898, No. 17) makes a careful and critical review of the clinical and experimental work that has been done in connection with this subject. He finds that the pericardium and heart are not regions where surgical intervention is always contraindicated. Surgical intervention with relief from conditions that threatened life has been followed in a number of instances by recovery. Foreign bodies that have entered the pericardium and wounded the heart itself have been removed, the pericardium has been emptied of clots, while suppurative pericarditis has been cured by pericardotomy and drainage.

Before intervention is attempted the condition of shock that is generally present must be overcome. This is accomplished by the intravenous injection of physiological serum and other fluids. The old method of venesection has been abandoned, and it has been found that there is no greater danger by the new method of producing fresh hemorrhage. Intervention should not take place while the heart is weak, and nothing should be done to enfeeble it. Anæsthetics should be avoided or used only in a very slight amount, without full anæsthesia.

The method of intervention is influenced by the form of injury that requires it. If the injury is of the nature of a puncture or prick as by a needle, the foreign body should be removed. If the volume of the foreign body is greater it is better to operate where everything is in sight rather than to trust to the closure of the wound by a contraction as the body is gradually withdrawn. The pericardium and, if necessary, the heart is laid bare, sutures are placed in position, the foreign body removed, and the wound closed immediately by drawing the sutures.

Where an incised wound of the heart is suspected the symptoms must be the guide. Secondary intervention has succeeded in a number of cases, and intervention must be postponed till the symptoms indicate the necessity. The complications to be watched for are hemorrhage and pericarditis. In suppurative pericarditis the universal opinion is that it should be treated as all other forms of abscess in serous cavities.

In hemorrhage the question is still *sub judice.* Immediate intervention is never indicated as spontaneous arrest often cures. Therefore, if the area of pericardial dulness remains stationary and does not increase, expectant treatment is indicated. When, however, there is an aggravation of the general condition, with pallor, weak pulse, syncope, an augmentation of precordial dulness, weakening of the sounds of the heart, and recurrent external hemorrhage, intervention is indicated. When possible the track of the wound should be examined before opening the pericardium.

Further Observations on Coxa Vara.—WHITMAN (*New York Medical Journal*, January 21, 1899) reports an additional series of twenty-two cases of this disease. He believes that it is much more common than is supposed and that many cases are treated as cases of tubercular disease. Coxa vara is a depression of the neck of the femur, in most instances following the line of least resistance, downward and backward, or even downward and forward, and occasionally directly downward. It is one of the group of deformities of the lower extremity due to inherent or acquired weakness of structure or to disproportionate strain, or both, in which knock-knee, bow-leg, and weak foot may be included.

Coxa vara is to be detected only by physical examination. The points developed are: the trochanter is elevated, prominent, and displaced, as may be demonstrated by Nélaton's line and Byrant's triangle, the actual shortening of the leg and the peculiar and unequal limitation of the range of motion dependent upon the deformity. In progressive cases forced passive motion causes discomfort, and at times it may be resisted by voluntary and involuntary contraction of the muscles. This is, however, unusual. There is commonly a certain amount of muscular atrophy, more marked in the thigh than in the leg, which corresponds to the duration and to the degree of the disability.

The condition is probably the result of an inherited or acquired weakness, either of position or structure; it may be the important predisposing cause of the deformity. The exciting cause would be the instability of rapid growth, overstrain, overweight, and injury. Improper surroundings, insufficient nourishment, or debility from any cause, undoubtedly lessen the resistance of the bones as of other parts, but the presence of actual local disease is by no means necessary to explain the deformity.

The preventive treatment, if a diagnosis has been made in the early stages, may succeed, by the use of the perineal crutch and removing the strain of over-exertion, in checking its progress. This should be accompanied by massage, passive motion, and a limited amount of exercise, with passive forcible manipulation of the leg in the direction of limited motion.

The operative treatment consists in correcting the deformity by removing a cuneiform section from the base of the trochanter. The author has had success in the three cases treated in this manner. This operation is seemingly indicated in cases occurring in early childhood. Linear osteotomy below the great trochanter is sometimes valuable in enabling one to correct marked deformity.

In addition to thirty cases of coxa vara the author has seen fourteen cases of fracture of the neck of the femur in children. The majority of these cases were diagnosed as hip disease when sent for treatment. Before these cases can be properly classified an anatomical basis must be found by eliminating non-tubercular affections.

Bloodlessness as a Local Anæsthetic.—KOFFMANN (*Cent. für. Chir.*, 1898, No. 40) calls attention to the fact that bloodlessness as produced by the elastic tourniquet makes the area below the band anæsthetic if a sufficient time is allowed to elapse before the operation is undertaken and if the area immediately below the bandage is not invaded. The bandage must in all cases be very tightly applied.

BRAUN (*Ibid.*, 1898, No. 43), in commenting upon this article, shows that it is only a revival of an old method which has long ago been rightly discarded. The anæsthesia is not produced by the mechanical obstruction of